

SATURDAY, NOVEMBER 1, 1873.

ORIGINAL COMMUNICATIONS.

CASE OF ECLAMPSIA IN A NEW-BORN INFANT.

BY ELLWOOD WILSON, M.D.

THE following case is of some interest as illustrating one of the rarer unavoidable evils following the use of the forceps in prolonged and difficult labors.

Second pregnancy; head-presentation, fourth position (vertex to right sacro-iliac symphysis). Ether administered to modify the intensity of the pains, but not beyond slight muscular relaxation. The forceps were applied *without difficulty* to the sides of the child's head, and traction made with each returning pain during a period of three hours, until delivery was effected, the grasp of the instrument being relaxed during the intervals between the pains. The labor was rendered difficult by narrowing of the pelvic outlet; its whole duration was thirty-two hours. The child, a male, and of large size, seemed feeble when born, but reacted pretty well. It was greased and wiped, washing being interdicted, and simply wrapped in a blanket, kept upon its right side, ten drops of brandy being given every two hours in milk and water, equal parts. The head was moulded by pressure, and slightly marked by the blades of the forceps. Twenty-four hours after birth it seemed stronger, and permission was given the nurse to wash and dress it. Some exhaustion followed, and in a short time two convulsions occurred in quick succession, and, after an interval of nearly an hour, a third during my visit. The muscles of the respiratory tract were chiefly affected. The child suddenly ceased breathing; its surface became livid, its extremities cold. At first the heart's action was not altered, but during the continuance of the fit the pulse gradually failed, until at length it was scarcely perceptible. The thumbs were drawn slightly inward; there was no general muscular rigidity, no twitching of the face or extremities; the muscles of the eyes were not affected. This convulsion lasted two minutes, and terminated with a long, deep inspiration, followed by a fit of crying, immediately upon the introduction of a small conical lump of ice into the rectum. Convulsions recurred at intervals of from fifteen to forty minutes during fifteen hours, but the use of the ice, whether at once at the beginning of the seizure or after waiting until it had lasted some moments, was invariably followed almost immediately by the long inspiration and fit of crying,—the relief of the paroxysm. Every effort at deglutition caused a return: the treatment was therefore administered by enema. It consisted of five grains of bromide of potassium every two hours, alternating with fifteen drops of brandy in milk. The child was kept strictly upon its right side, and surrounded with artificial warmth. The attacks gradually decreased both in intensity and frequency, and finally ceased. Stimulus and small doses of the bromide were continued for several days. More than three months have since elapsed without the recurrence of a symptom referable to the nervous system. The child is well nourished, and apparently in perfect health. The contraction of the outlet of the pelvis in the mother of this child is very marked. Her first child was born after a difficult labor of thirty-six hours, but so enfeebled that it died in a short time.

I have given the history of this case at some length,
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in order to point out what I believe to be the cause of the convulsions: that is, the prolonged pressure of the ends of the forceps-blades at the base of the cranium, producing some slight derangement of relations of the structures of the brain at its base, and consequent *tendency* to convulsions. This tendency—not strong enough to overthrow the equilibrium of the nervous system as long as the child's general strength did not fall below a certain condition—developed into convulsions as soon as it was reduced by the insignificant shock of the bath and exhaustion of dressing, to which children, as a rule, may be exposed with impunity on the second day.

Mere moulding of the head by pressure of the bony walls of the pelvic canal—a pressure exerted upon the cranium at its greater diameters, and not upon the base—has not, in my experience, given rise to convulsions. W. J. Little, however (see Transactions of the London Obstetrical Society, vol. iii. p. 293), remarks that convulsions are very apt to occur immediately upon or at varying periods after difficult births, and attributes this symptom of disorder of the nervous system in the great majority of cases to the congestions resulting from partial asphyxia, rather than to mechanical injury of the nervous structures. But he quotes North as saying, "It cannot be doubted that convulsions occasionally arise from excessive and long-continued pressure of the head during protracted labor." Cazeaux fails to enumerate convulsions among the accidents following the use of the forceps. Spastic rigidity is apt to occur subsequently.

The forceps used were the short forceps of Davis, and there was no difficulty in locking the blades; although there is no doubt that the change in the shape in the head through long compression, increasing the occipito-mental diameter, interfered with the coincidence of the curvature of the forceps with that of the head, and in so doing brought the ends of the blades to press more directly upon the cranial base. Graily Hewitt in 1861 called attention to the fact that this change in the shape of the head renders the application of the forceps difficult, and suggested in such cases the use of a longer blade with a less decided curve.

Ether, which always when freely used and long continued enfeebles the child, and the unguarded use of which is without doubt in the present era of obstetrics the cause of multitudes of still-births, does not cause convulsions.

The treatment of the paroxysm by ice to the anal region, or by small pieces of ice introduced into the bowel, was attended by the most marked results. More than once the convulsion, unusually prolonged, seemed to be passing into coma, when the ice quickly brought it to an end.

Certainly in this case the feebleness of the child, and the fact that it was but a day old, forbade the use of most of the means recommended for the relief of the convulsive paroxysm, while the severe type of the convulsions and the imminent danger of death precluded the use of others less speedy in their action. By the application of ice to a part so largely supplied with nerves, a sudden powerful

impression was produced upon the spinal system, and that by a remedy at once near at hand, entirely controllable, and incapable of producing depressing or traumatic secondary effects.

DILATATION OF THE FEMALE URETHRA.

BY OSCAR H. ALLIS, M.D.,

One of the Surgeons to the Presbyterian Hospital.

I REPORT the following cases, not that they present any new feature, but rather as confirmatory of cases previously favorably commented upon by other writers.

Case I.—Mrs. —, 58 years of age; vesical calculus; had often passed concretions during micturition, and some of large size. I visited the patient every day or every second day for about two weeks, and at each visit effected a greater dilatation of the urethra. As soon as I could introduce the forefinger, Dr. Turnbull, who had placed the case in my hands, and Dr. Curtin, assisted me in completing the dilatation and the extraction. There proved to be two large calculi, and the circumference of the larger, when grasped with the ordinary lithotomy forceps, was three inches and a half. At the suggestion of Dr. Turnbull, the bladder was injected with cold water, to check any bleeding that might ensue had the walls of the bladder been injured, and, to the surprise of all present, not a drop was permitted to pass the already contracted sphincter. The patient made a rapid recovery, without suffering a moment's incontinence of urine.

Case II.—Mrs. —, æt. 53; married; the mother of three children. In the spring of 1872 she began to complain of pain in the hypogastrium. The pain was neuralgic in character, not constant, and aggravated under certain changes of the weather.

The slightest distention of the bladder gave her pain, and the sudden stoppage of the urine during micturition led to the suspicion that calculus might be present. Still, the explorations of the bladder with the sound, and examination of the urine, gave no satisfactory clue to the malady. Baffled in every attempt to give relief, Dr. Groom, of Bristol, in whose care the patient was, requested me to dilate the urethra and make a digital examination. This was effected in about fifteen minutes under ether, and a polypus was found at the base of the bladder, attached to a roughened thickened portion of the bladder at a point corresponding to the right side of the pubes. The diagnosis was thus established, the difficulty removed, and with the happiest results, and, what especially concerns us now, no incontinence of urine.

The mode of dilatation will be noticed in each case. In the first it was prolonged and vexatious to both patient and physician. In the second it was rapid; yet in the first the dilatation may as justly be called *rapid*,* for when I went to the patient the urethra would only admit the finger, and in about fifteen minutes it had been dilated to a circumference of three inches and a half.

I can see nothing to favor gradual dilatation, whether the object be to explore the bladder with the finger or to extract foreign bodies from it. The female urethra is under all circumstances very dilatable. There are many well-authenticated cases of

large calculi having escaped with the urine from the bladder, and a case is reported of obstructed vagina in which coitus took place habitually through the urethra.

During the latter stages of dilatation the progress must be gradual, for the limit of distensibility is being reached, beyond which rupture of the fibres must take place.

The instrument used—and a most admirable one for the purpose—is depicted in Gross's Surgery, under "Dilatation of the Female Urethra."

NOTES OF HOSPITAL PRACTICE.

JEFFERSON MEDICAL COLLEGE.

CLINIC OF PROF. S. D. GROSS, M.D.

Reported by J. B. ROBERTS.

REDUCTION OF AN AXILLARY DISLOCATION OF THE HUMERUS OCCURRING DURING PUERPERAL CONVULSIONS.

MRS. D., aged 20, was seized during parturition with puerperal eclampsia, in which the convulsions were so violent that she sustained from muscular contraction an axillary dislocation of the right humerus.

The great variety of motion allowed the arm necessitates a peculiar mechanism of the shoulder-joint, which renders it especially subject to dislocations; and we accordingly find that of all luxations in the body that of the head of the humerus is the most frequent.

The head of the bone may be thrown into the axilla, upon the ribs below the clavicle, or backwards upon the dorsum of the scapula, constituting respectively the axillary, thoracic, and sub-spinous forms of the dislocation. The thoracic and sub-spinous varieties are very rarely seen, but that into the axilla is of frequent occurrence, generally, however, being produced by direct violence, and but seldom by muscular contraction. The injury as a result of puerperal convulsions is very uncommon, though instances of dislocation by muscular contraction during epileptic seizures are met with not unfrequently.

In the patient the contour of the shoulder is decidedly changed by a marked flattening where the roundness of the deltoid should be, and an unnatural prominence of the acromion, under which there is a hollow, caused by the removal of the head of the bone from its normal position. The distance from the top of the shoulder to the axilla is materially increased, differing from the uninjured side by at least an inch; the arm is lengthened; upon rotation of the limb the head of the humerus can be distinctly felt in the axillary space; and the elbow is thrown out from the body by the tension of the deltoid muscle.

It has been stated by some surgeons that in axillary dislocation of the humerus the patient cannot bring the elbow in front of the body, so as to grasp the opposite shoulder with the hand; but although this is true in this instance, it was not in the case brought to the clinic two weeks ago, where the patient could place her right hand on the left shoulder without any difficulty whatsoever.

In injuries about the shoulder-joint a careful examination is always imperatively demanded; for, though the symptoms of dislocation are generally characteristic, yet there are obscure cases which the surgeon may fail to recognize, unless the investigation be thorough and complete.

* I use the term *rapid* as implying that the dilatation has all been accomplished at a single visit, and not with reference to the number of minutes necessary to accomplish it.

When the dislocation is of recent date, reduction can be readily effected; but when left until a considerable period of time has elapsed, the operation is generally unsuccessful, and frequently attended with great danger to the important vascular and nervous structures in the axilla.

As the luxation in this instance occurred only three weeks ago, I shall endeavor to reduce it by using my heel as a fulcrum in the armpit and making extension on the forearm with both hands. The patient is thoroughly anæsthetized, in order to relax the muscular system, and then, having put a folded towel in the axilla, I place my heel, divested of the boot, against the luxated bone, making at the same time strong extension at the wrist, and by this means cause the head of the bone to slip into the glenoid cavity with a snap.

If this had been an old dislocation, it could not have been reduced by this simple manœuvre, but would have required the application of a much greater amount of force, which even then might have proved ineffectual, or have been followed by such disastrous consequences as rupture of the axillary artery or vein.

The period after which the surgeon should refrain from undertaking reduction cannot be fixed absolutely. It depends upon the amount of plastic inflammation that has occurred, and upon the degree of motion of the joint, which, if considerable, may be assumed as evidence that a false socket has been formed, and that attempts at reduction will be useless.

After reduction it is important to keep the arm supported in a sling, and to prohibit extensive motion in any direction, lest there be a recurrence of the displacement. The subsequent inflammation must be combated upon general principles, and the occurrence of ankylosis prevented by passive motion.

STRICTURE OF THE OESOPHAGUS FROM SWALLOWING LYE.

Mary H., aged 2 years, drank about three months ago some of the "concentrated lye" of the shops, which by the resulting inflammation has produced organic stricture of the oesophagus.

The powerful alkali, having corroded the mucous membrane of the lips, tongue, and throat, set up an intense inflammation, during the progress of which the destroyed tissue came away in large patches, and the patient was unable to swallow any solid food. After the expiration of six weeks the inflammatory action subsided sufficiently to permit the deglutition of bread; but a short time subsequently this became again impossible, so that at present nothing but liquids can pass into the stomach; and even these are at times ejected by regurgitation.

One of the most frequent causes of organic strictures of the oesophagus is inflammation arising from the action of acids or alkalis that have been inadvertently swallowed, which even when not very concentrated are capable of producing a degree of inflammation sufficient to cause contraction of the calibre of the tube.

The most frequent position of the constriction is opposite the cricoid cartilage, for in that situation the oesophagus has normally the smallest diameter. Just above the stricture there is usually a dilatation of the tube, the result of pressure exerted by the food arrested in its downward course by the obstacle.

Here is a specimen, for which I am indebted to Dr. Barton, my chief assistant, taken from a child who died with a stricture of the gullet. The constriction is several inches long, and entirely impervious, so that the patient perished from inanition, as no food passed into the stomach for some time previous to death.

The only available treatment in stricture of the oesophagus is long-continued dilatation with the bougie; but in this case, since it is impossible to have the co-opera-

tion of the patient, it is not judicious to endeavor to carry out this plan. The administration of chloroform at every introduction of the instrument would be impracticable; and, unless completely anæsthetized, the child might by struggling cause the operator to rupture the already diseased tube. Palliative measures must therefore be adopted, and the patient's strength kept up by nutritious liquid food, for it is probable that the child does not obtain sufficient nourishment through the narrowed oesophagus to meet the requirements of the system.

ONYXITIS OF THE INDEX FINGER.

The left index finger of this girl has been sore for two months, being now indurated and enlarged and having a curious bulbous appearance. The trouble began with a small ulceration at the root of the nail, which, gradually increasing in extent, ran around the circumference of the nail, and entirely destroyed it. There is now no nail upon the finger, but in its place a foul, unhealthy-looking ulcer, which gives the girl, particularly during the night, a great deal of pain.

The patient thinks the disease was brought on by a slight injury which the finger sustained a short time previous to the appearance of the ulcer. This is quite probable, as onyxitis, or onychia maligna, as some designate the affection, has not unfrequently some external violence for its immediate exciting cause, though it is in reality a manifestation of constitutional taint, being almost invariably dependent on hereditary syphilis.

In treating onyxitis the bowels should be kept well opened, and mercury administered until the occurrence of slight ptialism shows that the system has been brought under its influence. As it is often well to employ the iodide of potassium, sodium, or ammonium, in combination with the mercurial, this little girl shall take three times a day one grain and a half of the iodide of sodium, which is less nauseating than iodide of potassium, with one-twentieth of a grain of the corrosive chloride of mercury. In addition to this constitutional treatment, she shall use emollient poultices and sugar of lead locally.

Depletion of the parts by scarification or by means of Swedish leeches would no doubt be attended with very beneficial results; and it is possible that this may be resorted to hereafter in conjunction with the foregoing treatment.

ST. MARY'S HOSPITAL.

SERVICE OF JAMES CUMMISKEY, M.D.

Reported by JAMES A. MEARNS, M.D.

ABSCESS OF THE LIVER.

ROLAND J., æt. 44, married man, proprietor of a liquor-house in this city, was admitted to the medical wards August 29. His condition on admission was as follows:

Patient was suffering from a high fever, frequent pulse, intense headache; very restless and irritable (had had a severe chill the day previous); complained of pain in right side on inspiration; breathing interrupted, tongue heavily coated, bowels costive; had slight hacking cough, but no expectoration. On inspection, the right side was bulging slightly. On percussion, dulness of base of right lung, and area of dulness of liver enlarged.

Diagnosis at this time was pleurisy. He was treated by blisters over seat of pain; a fever mixture was given; bowels opened by saline purgatives. In two weeks he was able to walk around the wards, and a few days afterwards went home for a day. He came back, and was apparently convalescent.

On the 21st of September he went down to service in

the chapel; the room was cold and damp; after going up-stairs he was seized with a chill, and had to go to bed. This time no symptoms indicating a return of the pleurisy were discovered, but each day the swelling in the right hypochondriac region increased. The liver became enormously enlarged. Dulness as high as upper margin of fourth rib, and extending three inches below margin of the ribs. The patient emaciated rapidly; had slight diarrhoea; appetite very bad; tongue became heavily coated; breath offensive; skin slightly jaundiced; pulse frequent, and scarcely perceptible. He was given blue mass ten grains daily, with nitromuriatic acid, diluted, fifteen drops every four hours, for five days. At this time he was given stimulants alone, and poultices applied over the swelling. This was continued for nine days. Fluctuation was perceptible. An exploring-needle was introduced, which contained pus on withdrawing it. The following morning the swelling had almost entirely disappeared. He was passing pus by the bowels. He became delirious, and died in twenty-eight hours.

Post-mortem examination revealed the following condition. A cavity occupying nearly the whole of the right lobe, ulceration through into the duodenum, and also into the peritoneal cavity. Over two quarts of pus were found in the liver and abdominal cavity. Adhesions had formed to the parietes opposite the fifth, sixth, and seventh ribs. The left lobe was somewhat enlarged and softened.

TRANSLATIONS.

ON THE OLEO-STEARATES, AND PARTICULARLY ON THE OLEO-STEARATE OF ZINC.

Translated from the *Bulletin Générale de Thérapie*, Sept. 1873,

BY ARTHUR VAN HARLINGEN, M.D.

WE desire to call the attention of practitioners to the advantages which these compounds present, both as entering into particular pharmaceutical preparations, and as to the therapeutic results which may be hoped for from their use.

Oleo-stearates (or rather oleo-stearo-margarates) are salts which have as bases oxides of the various metals, and as acids the oleic, stearic, and even margaric; and which are extracted from fatty substances by saponification.

Two processes may be employed for the preparation of these salts: one, which is direct, consists in mingling in presence of a certain quantity of water the different oxides which it is desired to combine, and the acids, or rather the natural fatty substances which are found in combination with glycerin under the names of oleine, stearine, and margarine. In this process the action of heat is often necessary, in order that the combination may be more easily effected.

This method is similar to that by which almond soap (oleate of soda), white soap, and lead plaster (oleo-stearo-margarate of lead) are prepared.

In other cases, and particularly where the oxide which is to enter into combination is very slightly alkaline, or of feeble solubility in water, and where, on the other hand, the oleo-stearate is insoluble in the same vehicle, it is necessary to have recourse to a second process, which permits of obtaining the salt indirectly and by double decomposition.

It is by this process that the oleo-stearates of iron, copper, mercury, etc., and of the various alkaloids, are obtained.

For this purpose a solution of almond soap is added in small portions to a solution of some soluble salt, with the base of which it is desired to obtain an oleo-stearate, until a precipitate is formed. Care must be taken always to employ an excess of the solution of soap, the presence of which excess is recognized by the milky tint of the supernatant fluid, the latter being clearly separated from the precipitated oleo-stearate.

That metallic salt should be chosen which precipitates most easily: thus, for iron or copper the sulphate, for mercury the per-nitrate, should be used; avoiding in the latter an excess of nitric acid, which possesses the property of decomposing the alkaline soap and setting free the fatty acids.

For the oleo-stearates of the alkaloids as proposed by M. Tripiér, the chlorides of morphia, quinia, etc., are used.

The salts, as we have said, offer as pharmaceutical preparations several advantages, which have been pointed out by various writers, particularly M. Jeannel.

They allow, by their easy solubility in fatty substances, the preparation of ferruginous oils, and pomades containing active principles (oleo-stearates of morphia, quinia, etc.), where the state of solution in the excipient in which they exist makes them preferable to similar preparations where the active principles are incorporated by simply mixing or are dissolved in water, and are perhaps much less easy of absorption.

Finally, the oleo-stearates lend themselves successfully to various therapeutical applications. To give a single example, we may cite the oleo-stearate of zinc, which, mingled with a convenient quantity of an unctuous excipient, as in the following formula, gives excellent results in the treatment of chronic eczema accompanied by itching:

- R Oleo-stearate of zinc (dry), 3 parts;
Mutton-suet, 15 parts;
Oil of sweet almonds, 15 parts.

Slowly incorporate the oleo-stearate of zinc with one part of the oil of almonds in a slightly warmed porcelain mortar, and add, little by little, the melted and partially cooled mixture of the remainder of the oil with the suet.

EPISTAXIS FROM A LEECH IN THE NOSE.—Dr. Amaducci was called to a boy aged 6 years, who had had obstinate epistaxis for a week, for which no cause could at first be assigned; the boy was healthy, and there was no family history of hemorrhagic diathesis. On being questioned, he said that the hemorrhage commenced some hours after he had drunk water from a brook. Cold water was injected into the right nostril, and the coagula were removed; a leech was then discovered adhering to the mucous membrane, and was removed by polypus-forceps. After this, the epistaxis ceased entirely. Dr. Amaducci believes that the leech was first taken into the mouth, and that it thence crawled into the nostril.—*Il Raccoglitore Medico*, No. 25, 1873; and *Allgemeine Medicin. Central-Zeitung*, Aug. 13.

TREATMENT OF ASTHMA.—Dr. Ad. d'Evot (*Rev. de Thérap.*) gives some directions as to the remedies to be used in asthma. Twelve grammes of flowers of sulphur, with one gramme of tartarized antimony, are mixed with honey and powdered gum and divided into sixty pills. Three of these represent the dose of Debreyne's powders, and one pill is given morning and evening.

Morning and evening a sheet of nitre paper may be burned in the bedroom or alcove of the patient. The paper may be prepared of white filter-paper, dipped in a solution of nitrate in the proportion of a drachm to an ounce.—*The Doctor*.

PHILADELPHIA
MEDICAL TIMES.
 A WEEKLY JOURNAL OF
 MEDICAL AND SURGICAL SCIENCE.

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PUBLISHED EVERY SATURDAY BY

J. B. LIPPINCOTT & CO.,

715 and 717 Market St., Philadelphia, and 25 Bond St., New York.

SATURDAY, NOVEMBER 1, 1873.

EDITORIAL.

ORAL SURGERY.

IN the *Dental Cosmos* for October is a very able editorial from the pen of Dr. James W. White, in answer to the question of the *London Lancet*, What is Oral Surgery? From it we extract the following, since it seems to us to contain as forcible an argument as can be made in favor of "Oral Surgery:"

"An oral surgeon is one who, having received a general medical and surgical education, is drawn by interest or inclination to the special study and treatment of all abnormal conditions of the mouth, as are others to certain lines of practice now long enough established to have recognition as specialties. Just where such special practice shall begin, what it shall include, and where it will find its limitations, will depend, as in the practice of every other specialty, on the inclination and capabilities of the practitioner.

"If, as suggested by the *London Lancet*, it finds its boundary in 'stopping and extracting teeth,'—limited to a routine of mere mechanical manipulation,—the attempt to appropriate on such a basis of work or merit the honors of a learned profession is simply to court ridicule; while, on the other hand, to attempt to be an oral surgeon without the foundation of a medical education is neither more nor less than quackery. The *Lancet*, familiar apparently with only that class of dentists who are known among us as 'tooth-carpenters,' is astonished when a dentist aspires to do anything higher than 'to stop and to extract teeth.' Query: Is London dentistry not yet beyond the days of Paré? But, though unknown to the *Lancet*, there are in England, as well

as in this country, those in the dental profession not unknown to fame,—men who have earned, by study and practice, the title of oral surgeon; whose experience and proficiency in the treatment—medical, surgical, artistic, and mechanical—of all lesions of the oral cavity entitle them to a name indicative of special knowledge and skill equally with those to whom are freely accorded the titles of aural or ophthalmic surgeons.

"To deny recognition of the force which is developed by concentration is simply absurd. It then only remains to inquire if the lesions of the mouth are sufficiently serious and of such special character as to justify devotion to their study and treatment as a special branch of medical practice. No surgeon, we think, will deny that they are among the most serious and fatal of the lesions of the body, and that their treatment demands a degree of knowledge and skill which renders this department the most difficult in the range of a general surgical practice. A vast amount of suffering and disfigurement, and deaths not a few, are fairly chargeable to the malpractice, or want of practice, of those who, however learned or skilful in other directions, are incompetent to treat dental and associative lesions, because of having made no special study of the subject.

"That the majority of those now practising dentistry are worthy, in any wide sense, of the title of oral surgeons is not claimed. Too many, it may be, are quite satisfied 'to stop and to extract teeth;' but in the ranks of the profession are men whose ambition has a wider range, and who are acquiring a legitimate reputation in the medical profession as specialists.

"That the profession, now considered by the *Lancet* as devoted to a strictly mechanical pursuit, is to mean, in the near future, vastly more than this, we firmly believe. Let the young men now entering the ranks understand that the dentist is soon to be assigned his true position, either as a mechanic or a specialist in medicine. There cannot much longer be any middle ground. He is to blush when called doctor, or is to feel himself qualified to perform a doctor's duties."

In the address to the Canadian Medical Association, given at their late meeting by their president, the other side of this discussion is earnestly upheld; and the force and humor of the following extract are such that no apology is needed for its introduction here:

"Oral surgery carries the science from the top of the mouth above, past, and including, all the teeth, incisors, canines, bicuspid, and molars; past the uvula, past the fauces and anterior palatine arch; past the right, ay, and the left tonsil; past the posterior palatine arch to the epiglottis, catching up in its way the apertures of the various salivary ducts, and there leaves it. But it cannot, in this age of unrest, stop there. There is room and capitals to furnish titles to the laryngeal, the tracheal, the clavicular, the sternal, the costal, the intercostal, the axillary surgeon, the humeral, the pa-

rietal, the genital, the inguinal, the femoral, the popliteal, the pedal, the phalangeal surgeon; but here, again, we encroach on the *terrain* of the comfort-giving corn-doctor, the chiropodist, to whom I would suggest the appropriation of the title of D.C.S., Doctor of Chiropedal Surgery! And why not? A toe is as good as a tooth, and there are fewer of them."

We believe specialism in medicine to be a necessary outgrowth of the extension of our science and art; but, of course, there is a possibility of carrying it too far,—of dividing up too finely,—of pulverizing into dust instead of breaking into large fragments fitting into one another and capable of being joined together into a united whole. The question then is, Is oral surgery sufficiently distinct and of sufficient magnitude to be worthy of rank as a specialty?

In considering this, it seems to us of vital importance that we recognize the true position of *dentistry* and of *dentists*.

Argue and reason as we will, laud dentistry to the skies, or degrade it to lowest rank, the fact remains, that the great bulk of the work to be done is purely mechanical; that whilst a few practitioners, like our friend Dr. Garretson, may climb from tooth-plugging and tooth-pulling to the performance of the most serious operations, involving life itself,—from being skilful dentists to being as skilful surgeons,—the great bulk of the profession must spend their lives in a monotonous round of purely mechanical labor, labor in which mechanical and artistic skill along with personal qualities are the sole guarantees of success.

The higher education, the wider culture of the physician, though it may contribute, is in no sense a necessity, to such success; and just so long as this is true, so long will a very large proportion of dentists neglect that culture which, whilst it may be an ornament, is not a necessity for the practice of their profession. Here, it seems to us, the matter rests. Dentists—we mean the general mass—have at present no claims to be recognized as representatives of a branch of our profession; many dentists are doctors, some of them are "oral surgeons," and as such we receive them into the brotherhood; but the great mass must probably always remain as they are at present,—*dentists*,—worthy citizens,—we do them no disrespect,—artists of ability, many of them,—but yet in no sense practitioners of medicine, in no sense entitled to recognition as such.

The professions of dentistry and of medicine may be conjoined in one person, but they are essentially distinct, and a man may assuredly be an

excellent dentist without being a doctor, or an excellent doctor without being a dentist.

In truth, we can see no necessity for "oral surgery" being a specialty. Is cancer of the jaw different from cancer of the rib, or any more different from cancer of the rib than the latter is from cancer of the vertebra or cancer of the tibia? Is every bone to have its specialist? In such a specialty as the eye, profound study of sciences and the use of instruments not employed by the general surgeon are necessary; but not so with "oral surgery."

Further, we see no reason for believing that a man can take out a jaw-bone or diagnose an epulis any better for knowing how to plug a difficult molar or to counterfeit with consummate skill a lost incisor.

Far better preparation for such work, it seems to us, is long-continued daily practice in resecting other than jaw bones, and in diagnosing tumors in other parts of the body than the face,—practice to be obtained only in the wards of the general hospital and the office of the general surgeon, not at all in the usual work of the dentist.

Finally, oral surgery has no natural boundaries,—no Rhine or Pyrenees which shall limit it. This very day, chancing to be at the clinic of the great apostle of oral surgery already alluded to, we saw present three cases, the first of which was an erectile tumor of the vertex, the second an occipital tumor, believed to communicate with the brain and to be arachnoidal. We can conceive of the oral surgeon crawling downwards to the anus; but how arachnoidal tumors and cephalic varices are connected with the mouth passes our comprehension.

We would like to see dental schools attached to our medical colleges, and opportunity afforded to our medical students to learn something of diseases of the teeth, or even, if they like, to become practical dentists. We believe that in many parts of our country the practice of dentistry would afford training in the use of the fingers, occupation and honorable support to young, unemployed, almost starving, surgeons, and, at the same time, open the paths to the higher fields of their life-work.

In very many of our country towns and villages even respectable dentistry is a lost art, or rather an art that has never been found. A very few months' instruction would enable any young physician of a mechanical turn of mind to extract teeth and to plug, under ordinary circumstances, with credit to himself. The work of two or three hours would give him at least a bare livelihood, and at the same time offer excellent opportunities for gaining the confidence of his neighbors.

This is no mere fancy sketch: we have known

the door to high success as a practitioner of medicine opened in this way.

ILLEGAL PRACTICE OF MEDICINE IN CONSTANTINOPLE.

A WRITER in a late number of the *Gazette Médicale d'Orient* calls attention to the prevalence of the illegal practice of medicine in Constantinople, and alludes to its legitimate effect as seen in a case which had lately created some stir in that city.

A young gentleman, feeling unwell one day, applied to a certain apothecary for relief. That worthy diagnosticated "worms," and put up a package of powders, which, he assured his victim, would kill the troublesome parasites.

The desired relief came, but in an unexpected form. After taking the first powder the patient fell into convulsions with tetanic spasms, and shortly died.

At the subsequent examination by the legal authorities it appeared that the apothecary had either given strychnia in mistake for santonin, or, what seemed more probable, had by some strange blunder made his powders from the receptacle containing strychnia, instead of from that in which white sugar was kept, the two "elbowing each other fraternally" on the shelf.

It would seem from the account of the writer above quoted that a stringent law relative to the qualifications of practitioners of medicine, and providing inspectors, etc., etc., does exist, but that, like some laws which might be mentioned nearer home, it is more ornamental to the statute-book than useful to the public.

ACCORDING to the London *Lancet*, at the recent meeting of the British Pharmaceutical Conference the subject of marking in some way prescriptions calling for unusual doses of medicine was discussed. A Mr. Hampson proposed that the initials of the prescriber be written in brackets immediately after the unusual dose, thus:

Tr. digitalis, ʒss [J. R. L.]

and asserted that this was always done in this country (United States)!! In Germany and Austria, it is stated, it is the custom to put an exclamation-mark. We think the adoption of some such custom with us would be very well, and would tend to aid apothecaries in detecting those mistakes in prescribing which every practitioner makes sometimes in his life.

IN another column will be found a letter from Prof. Gross, in regard to the Miller Memorial Home. Whilst endorsing the sentiments of the venerable professor to the fullest extent, we would like to add one word. The popular reprints of the books of Dr. Miller have made money for some one. In all probability, not one cent of their earnings has ever found its way back to the author. Well may it be said of the American publishers of English books, "Other men labored, and ye are entered into their labors." Would it not be well for those who have accumulated fortunes by the publication of the works of Professor Miller and his colleagues to offer to his memory tithes from the storehouses filled by his toil?

WE learn from Boston that the Medical Department of Harvard University has just become the possessor of a large and valuable museum of models of diseases of the skin, the munificent gift of Dr. Edward Wigglesworth, of Boston, a gentleman well known in connection with the dermatology of the present day.

The collection embraces some two hundred models, the work of J. Baretta, of Paris, who is recognized throughout Europe as a most successful modeller and artist. The museum represents models of all of the commoner diseases of the skin, as well as a large number of rare forms, copied from the St. Louis Hospital collection. As works of art and accurate representations of disease, the pieces are remarkably fine, and portray the various affections in a most truthful manner. This is the largest and in fact the only complete museum of the kind in our country; and we congratulate Harvard upon being the recipient of such a generous donation from an individual.

WE learn from a recent exchange that the English government is offering iron hospitals to various unions throughout Ireland for the sums of £220 to £250 and £280, according as they are to contain twelve or twenty patients. They can be set up and made ready for occupation in a month, and are said to be with water-closets, nurse-rooms, wash-rooms, etc., complete. If they be what they seem, these iron hospitals appear to solve the question of hospital construction, costing, we should suppose, furnished, not more than one hundred dollars a bed.

In the abstract of Dr. Flagg's paper, p. 56 of our last issue, *cervical* twice occurs where it should be *crucial*.

CORRESPONDENCE.

MILLER MEMORIAL HOME.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES.

DEAR SIR,—Nearly two months ago I received from Dr. A. G. Miller, son of the late Professor Miller, of Edinburgh, a copy of the subjoined circular, inviting the co-operation of the medical profession of the United States in furtherance of the object therein stated.

In consequence of absence from the city and of various pressing engagements, I was reluctantly compelled to remain silent until the present moment. I now call the attention of my professional brethren to the subject, and sincerely hope that the appeal will meet with a prompt and hearty response.

There is the strongest reason why such an appeal should be generously met on this side of the Atlantic. For nearly a quarter of a century the surgical writings of Dr. James Miller, for many years Professor of Surgery in the University of Edinburgh, were the text-books of the medical students of our schools, and the works that were daily consulted by our practitioners, not only in cases of emergency, but as a part of their daily reading and contemplation. Both his "Principles of Surgery" and his "Practice of Surgery," edited by Dr. Sargent, of this city, passed, if I mistake not, through four editions in this country, and enjoyed for a long time an unbounded popularity. Even at the present moment they are used as text-books in several of the American schools of medicine. It is not too much, then, to say that the family and friends of Prof. Miller have a substantial claim upon our gratitude. But this, although a very important one, is not the only reason why we should extend a generous hand to this praiseworthy enterprise. Every contribution that is made in aid of such an object in behalf of a British professional brother at once assumes the character of an international courtesy, and, as such, it cannot fail to strengthen the bonds of good fellowship between the two nations.

The late Prof. Miller was not only a great writer and teacher, but a most accomplished practitioner, a Christian gentleman, and a warm-hearted philanthropist, never wearying in his efforts to suppress vice and immorality, and to improve the condition of the humbler classes of people in his own and in foreign countries.

Subscriptions may be remitted directly to Edinburgh, to the address of Dr. A. G. Miller, or to Dr. Barton, to my care, Eleventh and Walnut Streets. Medical journals, friendly to the object, will please copy.

I have the honor to be, very respectfully, your friend and obedient servant,

S. D. GROSS.

PHILADELPHIA, October 15, 1873.

"MILLER MEMORIAL HOME."—Shortly after the death of Prof. James Miller, a few friends raised, by private subscriptions, about £1600 as a memorial to him. Knowing the late Professor's long connection with, and deep interest in, Medical Missions, this sum was given towards

the purchase of 56 George Square, as a 'Home' for the students while being trained by the Edinburgh Medical Missionary Society as Medical Missionaries. This sum, however, was short of the purchase-money by £700. Since getting the house, the directors have had to spend more than £300 additional, in necessary improvements and repairs. They now appeal, therefore, to the public, for £1000 to enable them to clear off all debt upon the house, and to establish it as really the 'Miller Memorial Home.' Should more than the thousand pounds be received, it is proposed to place a suitable portrait or bust of the late Prof. Miller in the 'Home.'"

PROCEEDINGS OF SOCIETIES.

BIOLOGICAL AND MICROSCOPICAL SECTION OF THE ACADEMY OF NATURAL SCIENCES.

OCTOBER 6, 1873.

DIRECTOR W. S. W. RUSCHENBERGER, M.D., in the chair.

PRESENT—Drs. J. G. Hunt, McQuillen, Tyson, W. Hunt, and Richardson.

Visitors—Dr. Leffmann, Mr. C. E. Betticher.

Dr. J. GIBBONS HUNT exhibited specimens of, and made an important verbal communication respecting, the curious alga which polluted the reservoir of the Camden Water-Works last summer. During the course of his remarks he observed, "In July last the water in the basin at Camden, New Jersey, was found to be unfit for use. When drawn from the hydrants it was offensive to both taste and smell. On examining this water with the microscope, I found in it a plant, belonging to the Nostochaceæ, diffused in great abundance through the fluid in gelatinous masses of an opalescent or faint olive-green color. These jelly-like masses were much broken up, indeterminate in form, and enveloped innumerable spiral and brittle filaments, each having from three to fifteen turns.

"Cells of two kinds make up the filaments of this plant. Several subquadrate cells, about $\frac{1}{1000}$ of an inch in diameter, are arranged in linear series; then, at nearly regular intervals, globular cells—perhaps heterocysts—of equal size, and about the same diameter as the other cells, are interposed. Both kinds of cells are filled with granular contents. Owing to the extremely brittle character of the filaments, it was impossible to tell how many spirals completed an adult plant. If placed in pure water, all the cells became quickly separated, and the ripest exploded like miniature bombs, scattering their granules all round. This made it very difficult to preserve a specimen. By using a medium of the same density as the gelatinous water, I have succeeded in preserving a slide of this interesting plant, which I exhibit to the Section, quite unaltered in appearance.

"It is possible this plant is the same that Mr. Thompson found in Lake Ballydrain, near Belfast, Ireland, and described as *Trichormus Thompsoni*, in the *Mag. Nat. Hist.*, vol. v., 1837. It is characteristic of the Nostochaceæ to increase with great rapidity under peculiar conditions. During June of this year, little or no rain fell on the Camden basin for nearly thirty consecutive days, and the sun shone with almost unobstructed power on the still surface of the water. I venture to mention the subject at this meeting, because I am not aware that the plant has been found before in this

country, and there are no correct figures of it in the books."

Dr. WILLIAM HUNT inquired if any diseases were especially prevalent in Camden at the time this alga made its appearance and flourished in the reservoir.

Dr. J. G. HUNT did not know of any which prevailed to an unusual degree.

Dr. JAMES TYSON asked if Dr. HUNT could suggest any remedy for the exuberant growth of this plant.

Dr. J. G. HUNT replied that the only one which had occurred to him was the plan of continued agitation of the water, as, for example, by forcing it to the top of a tall stand-pipe and letting it overflow into the basin from a considerable height, thus mechanically breaking up the spirals of the alga and interfering with its growth.

Dr. J. G. HUNT also showed the inoculating vessels in a leaf of the *Euphorbia ippecacuanha*, and likewise a series of receptacles in the same plant, reminding one of the air-cells of the lung. He remarked that he exhibited them as specimens of a new style of work (the method for which he would lay before the Section when perfected), that would do away with much of the labor of dissection, and display vegetable structures in a unique manner, which he believed could not be equalled in Europe or America.

Dr. RUSCHENBERGER inquired whether drawings or photographs had been made of the beautiful specimens brought before the Section by Dr. HUNT.

Dr. HUNT replied that no drawing or photograph could do justice to the views of these objects as afforded by the invaluable binocular microscope.

Dr. J. G. RICHARDSON suggested that by taking a photograph through each tube of the binocular microscope and afterwards combining these two pictures by looking at them in the ordinary hand stereoscope, we would secure a perfect and complete reproduction of the exquisite image in relief obtained by the aid of double-tubed instruments, and he recommended that the method should be tried at an early opportunity.

REVIEWS AND BOOK NOTICES.

ON THE MECHANICAL TREATMENT OF DISEASE OF THE HIP-JOINT. By CHARLES FAYETTE TAYLOR, M.D., Surgeon to the New York Orthopaedic Dispensary and Hospital, etc. New York, William Wood & Co., No. 27 Great Jones Street, 1873.

A practical book, by an intensely practical man. Guilty of no useless verbiage, indulging in no flowers of rhetoric, at times perhaps even doing violence to strict methods of construction, the author marches straight to his end, possessing the not trifling merit of making himself, as a rule, thoroughly understood.

His first chapter plunges incontinently into statistics derived from the hospital and dispensary of which he is chief, as well as from his private practice, from which he deduces the result, founded on the carefully-collected histories of about four hundred cases, that "disease of the hip-joint, at least so far as regards the mechanical treatment, may be regarded as essentially traumatic." This view has been maintained for a number of years past by Dr. Sayre, and is put forth with much vigor in Dr. Louis Bauer's Lectures on Orthopaedic Surgery. New York surgeons have indeed very generally adopted it. Its importance in relation to both prognosis and treatment cannot be overestimated; and the sooner we of Philadelphia make it a part of our creed, renouncing our antiquated notions of the necessary dependence of chronic affections of this or indeed of any articulation on a pre-existing strumous diathesis, the sooner shall

we be able to claim for ourselves the credit of an intelligent conservatism in their management.

While justly according to Dr. Henry G. Davis, of New York, the merit of being the first to combine locomotion with extension in the treatment of hip-disease, Dr. Taylor considers the splint which that surgeon uses inefficient. The advantages which he claims for his own modification are, that in reaching to the ground it entirely prevents concussion of the joint in walking, that in extending the entire length of the limb it controls its movements and accomplishes its extension much more effectively, and that by a special adaptation it overcomes adduction as well as flexion of the thigh upon the pelvis. These points appear to us to be well taken. In our own experience we have found all of these modifications to be of the greatest possible advantage; but, at the same time, it must be confessed that Prof. Sayre's splint has, in his own hands, been productive of results which scarcely warrant the severe strictures which our author passes upon it. These successful results are, no doubt, in a great measure attributable to the extreme care with which Dr. Sayre applies his adhesive straps and his admirable method of in-and-out bandaging. It is safe to say that few surgeons can use it with the same success.

The gist of the present little monograph, that which affords the justification for its publication, without which no author should dare to show his face, appears to consist in the attempt to methodize the process of extension, dividing it into stages which are the exact reverse, in point of order, of the stages of the disease, thus making it both easier and more complete; attempting for the distorted coxal articulation what Mr. Adams accomplished for the distorted tarsal articulations in talipes varus. He, it will be remembered, proposed to divide the treatment of that affection into two distinct periods, one of which should always be perfected before the second was begun.

Those who have conscientiously followed this plan, overcoming the lateral distortion by force directed through the transverse tarsal joint before attempting to bring down the heel by force directed through the ankle-joint, do not need to be informed of its superiority over the old, blundering method, which attempted all at once. Dr. Taylor does not tell us whether he derived the inspiration for his suggestion from Mr. Adams or not, but the similarity in the two modes of procedure is certainly close and suggestive. The two separate sets of muscles which produce distortion and demand extension in hip-disease are the adductors and the flexors. As the former have been the last to become contracted under the influence of the irritation in the joint, our author considers that they should first be relaxed, and that only when that object is effected can we hope to act with the greatest amount of efficiency on the latter. In order to accomplish this, he places the diseased limb on an inclined plane reaching below the foot and exactly adapted to its deformed position. To the limb thus supported and flexed he applies his splint, and (the patient retaining the dorsal decubitus) commences abduction by means of a powerful screw. When abduction is an accomplished fact, whether that be at the end of an hour, a day, or a week,—the last-mentioned being the longest period of time which he has found necessary to devote in ordinary cases,—he is ready to begin to lower his inclined plane and thus overcome the contraction of the flexors. The application of the splint of course assumes the employment of a certain amount of extension. The entire process of overcoming these contractions may occupy in difficult cases a fortnight. At the end of that time relaxation is complete, and all that we need is to keep up vigorous extension, allowing the patient perfect freedom of motion through the joint, an essential to a

return to a healthy condition. By this means, he claims, a resort to tenotomy is almost never necessitated. Our own practice is to overcome the contractions by means of forcible manipulations under anæsthesia, and immediately apply the splint and allow locomotion. We have had reason to feel tolerably well satisfied with the results thus obtained; but the plan here proposed is rational and scientific, and the author's acknowledged success should certainly lead to its having a fair trial. There are numerous practical apothegms scattered through the sixty-two superbly printed pages which the seven brief chapters of the work occupy, which we would gladly quote and enlarge upon did space permit. The illustrations are very unequal both in design and execution, but generally serve to convey the desired idea. What is unfortunately very unusual in an American medical work, they are all original. We would call the author's attention to the fact that Fig. 13, which is referred to on page 36 as representing the appearance of the instrument when applied, places it outside of the shoe, which we take to be an error.

THE DISEASES OF THE PROSTATE: THEIR PATHOLOGY AND TREATMENT. Comprising the Jacksonian Prize Essay for the Year 1860. By SIR HENRY THOMPSON. Fourth Edition. Philadelphia, Henry C. Lea, 1873.

The appearance of the fourth edition of this standard essay is proof that monographs of the higher order are not always the barren waste of "meritorious energy" that Dr. Tilt would have us think. Certainly few prize essays have been more highly prized and praised. The distinguished author informs us in the preface to the present edition that he found it necessary to make several additions, at the same time compressing existing material. We have always deemed the essay a model of its kind. It is terse in style, rational in method, and thorough in all its parts. From original anatomical work the writer passes easily to the consideration of morbid changes and their treatment. In no other volume that we recall is there to be found so good a description of acute prostatitis or abscess of the prostate gland. The same remark is applicable to the changes in the urethra from prostatic hypertrophy. Perhaps the most original chapter is the one entitled "The effects of enlarged prostate in relation to the function of micturition, retention, incontinence, engorgement, and overflow." This subject has received masterly treatment throughout; and one naturally refers to it as the best authority. The allusion to the internal meatus of the bladder, particularly to the instructive morbid appearances therein located, is provokingly insufficient. It would have been a point gained, in our opinion, had our author emphasized the direction which is too little heeded by pathologists,—viz., to open the bladder at its summit, in examination of all suspected lesions of the genito-urinary tract, prior to making the destructive incision along the urethra.

THE PREVENTIVE TREATMENT OF CALCULOUS DISEASE, AND THE USE OF SOLVENT REMEDIES. By SIR HENRY THOMPSON. Philadelphia, Lindsay & Blakiston, 1873. 8vo, pp. 72.

The little book before us is a reprint of two lectures given at the University College, London. The first lecture treats of the early history of calculus and its treatment: the second, of the treatment of stone in the bladder by solvents. After giving a brief résumé of "all the nauseous mixtures described from Pliny to Joanna Stephens and onward through Chittick, with his locked cans, to the nostrum-dealers of our own times," the writer states as his opinion that the most rational hope of success is secured in the early stages of uric acid calculus when by the liberal use of the salts of potash

—notably the citrate and acetate—the symptoms of nephritic and cystic calculus may be ameliorated, and in some cases entirely disappear.

SELECTIONS.

ALBUMINOUS EXPECTORATION.

II.

LET us pass on to the opinions enunciated by MM. Woillez and Marrotte, and see if *traumatic perforation* can give the key to albuminous expectoration as a result of thoracentesis. Woillez, in his *Traité des Maladies Aigues des Organes Respiratoires*, pronounces the opinion that puncture of the lung in thoracentesis is more common than is usually supposed. At the meeting of the Société Médicale des Hôpitaux on June 28, he dwelt upon the fact of recent puncture of the chest; on the physical and chemical similarity of the fluid extracted from the pleura to that expectorated; on the issue of a small quantity of blood by the canula; and, above all, on the presence of blood in the earlier portions of the expectorated liquid; finally, on the issue of bubbles of air through the canula during the course of the operation. He attributed the mischief to the operation itself, consisting as it does in plunging a sharp instrument more or less roughly and directly into the chest, without knowing, says M. Woillez, whether the lung be floating or not in the liquid, and whether it do not advance to meet the point of the instrument, and, likewise, not knowing if some local adhesion do not retain it within reach of this point. M. Woillez considers one of the best proofs of the lesion of the lung by the trocar to be more or less rapid expectoration, after puncture, of a fluid resembling that extracted from the pleura; and amongst the outward characteristics he cites one having a particular value in his eyes,—namely, that the expectorated fluid may be sanguineous. In the cases under consideration, however, not one of the true signs of perforation was noted; neither issue of blood through the canula, nor passage of air from the bronchial tubes into the pleural cavity by pneumothorax, is spoken of. MM. Marrotte and Woillez have never demonstrated any perforation, nor has any ever been found on necropsy. It is, besides, as pointed out by M. Hérard at the meeting of July 11, 1873, necessary to know if effusions followed by sero-albuminous expectoration were small effusions, and if the lung may have been injured during the operation. But, in M. Terrillon's twenty cases, in three only from one hundred to fifteen hundred grammes of fluid were removed; whilst in the others the amount rose from two thousand to five thousand five hundred grammes. Therefore, in the majority of cases the lung was removed from the thoracic wall, driven back to the vertebral column, and thus sheltered from the point of the trocar. M. Béhier points out, in his lecture on June 13, that it is an incontestable fact that if the albuminous expectoration arose from perforation it would not take an hour to come on: it would be as immediate and instantaneous as the injury itself, as in Boule's case already mentioned. In that case, the lung would have been wounded four times in succession, notwithstanding that every precaution against such an accident was taken. It is evident that this cannot be the fact, and consequently perforation of the lung by the trocar may be put aside.

We now come to the third explanation,—the passage of the pleural liquid into the pulmonary vesicles, and thence into the bronchial tubes. This will not detain us long, for it is acknowledged to be impossible; it is con-

tradicted by the anatomy of the lung, and by the physiology of combined absorption and circulation, which teach us, as M. Terrillon says, that the fluid passes into the vessels and is carried into the general circulation. Why, then, should not the pleural liquid be submitted to this physiological law? Besides, in bringing forward this explanation, the fact that the pleura loses its absorbent properties when it is inflamed and becomes covered with false membranes, is entirely lost sight of.

We now come to the fourth explanation, enunciated by M. Pinault in 1858, and repeated with much clearness and force by M. Hérard in 1872,—the *transudation of the sero-albuminous liquid through the alveolar walls* by means of rapid pulmonary congestion with pulmonary oedema. This is based on sound physiology and on pathological phenomena, and is upheld by the majority of physicians, MM. Hérard, Moutard-Martin, Béhier, Dujardin-Beaumetz, Brouardel, and others, and is demonstrated by clinical observation and necroscopic examination. Physiology explains this transudation as follows. Section of the pneumogastric nerves brings on a frothy effusion in the bronchi and a sanguineous engorgement of the pulmonary tissue. One of the two products of secretion is nothing but bronchial mucus; the other, which is most abundant, is serous matter. M. Jaccoud, touching on the oedema of congestion, in his *Elements of Internal Pathology*, says, "constituted by a serous exudation in the walls and on the free surface of the alveoli, oedema is the constant and necessary consequence of all pulmonary congestion of a certain standing." M. Charles Robin, in his *Traité des Humeurs*, acknowledges that the capillary network of the surface of the alveoli may, under the influence of either temporary or permanent congestion, allow a certain amount of fluid quite distinct from the bronchial mucus to exude. M. Moutard-Martin grapples with the question in a very clear and decided way. "You cannot," he remarks, "clinically establish your so-called pulmonary perforation, while on our part we do clinically establish the sero-sanguineous congestion of the lung, by the presence of slight dulness and subcrepitant râles, of pulmonary oedema and hæmoptysis." That it may be proved after death is shown in M. Gombault's case reported by Terrillon. In the explanation of this transudation, it is easy to understand that, when a lung has been compressed for a certain time, when it has been excluded from the air, that natural excitant, penetrating rather suddenly into the pulmonary vesicles, would produce irritation of the mucous membrane, and an excitement of the vessels which in a very short time would be followed by paralysis, of which the inevitable consequence is passive congestion with oedema. If we add to this the destruction of the epithelium which clothes the alveoli and strengthens the walls of the capillaries, the probability of MM. Hérard's and Moutard-Martin's explanation will be much increased.

In certain cases of albuminous nephritis, the desquamative congestion at the commencement allows the capillaries of the kidney to let the albumen escape into the tubules and mix with the urine; here the modified alveolar mucous membrane readily allows the albuminous serosity to filter through. Further evidence of the rapid congestion of pulmonary oedema, and of the expectoration resulting from this oedema, may be found in the analysis of the two fluids. The very complete researches of M. Dujardin-Beaumetz show that these fluids have a very distinctly marked difference of character. He says, "while both fluids contain urea, mucine, and albumen, the expectorated fluid only contains 1 part in 1000 of albumen; the other, on the contrary, contains from 66 to 88 parts in 1000. This difference in the analysis," says M. Dujardin-Beaumetz, "includes, in our opinion, the difference in the origin;

and we can now affirm that the expectoration is exclusively derived from the bronchial mucus."

Further, in favor of the theory of pulmonary congestion as an etiological condition of the accident in question, the different cases of albuminous expectoration after thoracentesis, observed by M. Louis Lande, Professor in the Bordeaux School of Medicine, must be recorded. He proves the non-identity of the two fluids in a decisive manner by citing the cases of Dr. Musson and Dr. H. Gintrac, in which the phenomenon came on after thoracentesis, performed for purulent effusion. To this may be added the conclusive proof given by MM. Revillout, Jalabert, Renan, etc. M. Revillout has applied himself specially to this subject; and the series of investigations which he has published in the *Gazette des Hôpitaux* for June and July are calculated to throw much light on this interesting problem. They are on very simple cases, attacks of albuminous expectoration not only arising without any thoracentesis, but even without the presence of any pleurisy.

In a series of clinical records, M. Revillout has accumulated a progressively significant number of cases, which, from their great theoretical and practical interest, deserve to attract the attention of physicians. In one of them, an old man, subject to attacks of asthma, did not at the time suffer, nor had ever suffered, from pleurisy. On two occasions he was seized with alarming crises, characterized by a cough, which at each expiratory movement brought up a mouthful of albuminous fluid tinged with blood, with which the patient soon filled a large basin.

In a similar case, M. Jalabert, of Carcassonne, rejecting all idea of a pleural origin for the fluid, especially as the patient was subject to similar attacks from time to time, which were completely relieved by bleeding, did not hesitate to diagnose pulmonary congestion with excessive bronchial secretion, and combated the attack by agents capable of exciting the contractility of the small vessels, such as ergotin and syrup of belladonna.

These cases, M. Revillout remarks, lead us to form more just notions of acute pulmonary oedema. Similar cases have also been described by Robert Bree and Laennec. These accidents are not brought on by asthma only; for Dr. Renan, of Saumur, gives a report of a similar case which might perhaps be considered as a manifestation of paludal infection. It is, then, to the fourth explanation of the phenomenon of albuminous expectoration that the balance of evidence inclines. The subject is one of great clinical interest, and deserves the attention of medical observers, with a view to the definitive solution of the question at issue.—*British Medical Journal*, October 11.

GLEANINGS FROM OUR EXCHANGES.

TREATMENT OF ENURESIS (by Dr. Buyelmann, of Cologne).—The author was induced by an article in the *Berlin. Klin. Wochenschrift*, 1871, No. 5, to try the syrup. ferri iodidi in a severe case of incontinentia urinæ. The patient was a young girl, thirteen years old, of nervous temperament, and anæmic. The principal complaint was the incontinence of urine, so severe as to prevent her from walking any distance from her home without wetting herself. In addition to generous diet, she took, for three weeks, syrup. ferri iodidi, seven grammes, ad aquæ, syrup. simp., ʒʒ ferri grammes; a teaspoonful every two hours. After a week's treatment there was a marked improvement, and in two weeks more she was discharged well.—*Berlin. Klin. Wochenschrift*, No. 6.—*Boston Med. and Surg. Journal*.

EXOPHTHALMIC GOITRE.—Boddaert (*Bull. de la Soc. de Méd. de Gand, Gaz. Méd.*, 1873, p. 141) experimented on rabbits with reference to the origin of this condition. Ligatures were placed upon the external and internal jugular veins at the base of the neck, and the two cervical cords of the sympathetic were cut. An exophthalmia resulted, continuing several days, diminishing gradually as the collateral venous circulation became developed and as the effects of the section of the sympathetic disappeared. Exophthalmia following the ligature alone, due to distention of the orbital veins, is much less pronounced. An enlargement of the thyroid is produced by section of the sympathetic and ligature of the inferior thyroid vein between the four jugulars. These experiments, combined with the discovery of lesions of the sympathetic, whose effects are analogous to those produced by section (atrophy of nerve-elements, hypertrophy of connective tissue) in a number of cases of Basedow's disease, are considered as explaining the phenomena of the disease. In exophthalmic goitre, an obstruction to the circulation occurs; the superficial veins, especially of the neck, become swollen; there is a tendency to hemorrhage, an increase of splenic and hepatic dulness, occasional dropsies, œdema, and the enlargement of the retinal vessels observed by Graefe. Boddaert hence produces this theory of exophthalmic goitre. In the majority of cases the pulsations of the heart increase in number,—120 to 200 even; this may continue for months. The veins are insufficiently emptied during the diastole; a venous congestion results, more marked from a more or less complete paralysis of the sympathetic. The effects become most marked in the eye and thyroid body, from the development of the retro-ocular venous system and the great vascularity of the thyroid. This theory is considered as explaining the observation of Trousseau, where the exophthalmia and the thyroid tumor came on during a night, the goitre disappearing suddenly and returning afterwards; also, the diminution of the exophthalmia and the thyroid body, as the heart beats less rapidly.—*Boston Medical and Surgical Journal*.

THE ELECTRO-MAGNETIC CURRENT IN THE SECOND STAGE OF LABOR (*Edinburgh Medical Journal*, September, 1873).—Dr. A. E. McRae details three cases of *inertia uteri* in which the use of galvanism was attended with very happy results, bringing on contractions when they had ceased entirely, hastening delivery, facilitating the discharge of the placenta, and counteracting a decided tendency to post-partum hemorrhage. He believes that this agent should be employed when the os is dilated or dilatable; when the uterine action has ceased, and cannot be aroused by stimulants, friction, or other oxytocic agents; when there is evidence of uterine action becoming weak, irregular, or intermittent; and when there is post-partum flaccidity of the uterus, or post-partum hemorrhage not caused by hour-glass contractions. The method of application is as follows. One of the electrodes is applied to the abdominal parietes, and retained by the patient's hands, with a layer of blanket between, to prevent the current entering by the finger. The other pole is placed against the perineum, and retained by folds of blanket or a small pillow. The force can be moderated or increased at will by the left hand of the accoucher working the "regulator" while the right hand manipulates the child's head. The electrodes are now attached to the machine, the current is set on, and, in obedience to a law in electro-physics, takes the shortest and most direct route from the abdominal to the perineal electrode, or *vice versa*. The uterus lying in this direct line shares in the influence, its fibres contract, and in so doing aid in expelling the uterine contents; its action

being limited by the electric force evolved, the quantity and condition of the muscular fibre of the uterus, and the patency of the passages. When the head descends and comes towards the perineum, the perineal electrode should be shifted to the coccygeal region, thus exercising a *vis a tergo*, and, by relieving the perineal muscles of their tonic contractions, allowing them to become flaccid and permit dilatation. The head is thus born in the proper line of the axis of the outlet, with freedom.

DIGITALIS IN ACUTE FEBRILE DISEASES (*The Practitioner*, September, 1873).—The question of the power of digitalis as a heart tonic in the adynamic fevers is a very important one, and is becoming more so as we recognize the frequency with which sudden failure of the heart is a cause of death in diseases running a protracted course, or occurring in subjects whose tissues were damaged by disease or intemperance.

Dr. Anstie believes that we are entitled to view muscular heart-failure in acute febrile diseases as essentially dependent upon an enforced rapid action, under high temperature, prolonged for a period which is excessive in proportion to the vital recuperative power of the cardiac muscular tissue. The same result will be produced in a shorter period if the tissues of the heart have been previously so modified by pathological degeneration as to render their restoration to a healthy state unusually difficult. The practical effect at which we should aim in such cases, merely for the sake of preserving the soundness of the muscular tissue, if for no other reason, is the simultaneous slowing and strengthening of the ventricular contractions; and clinical experience has shown that this effect may be most safely and surely produced by the use of digitalis.

Dr. Grimshaw has given one and a half ounces of the infusion of digitalis every three hours for five or six days together, not only with impunity, but with seeming benefit, in some cases of typhus fever; Wunderlich has administered daily thirty to fifty grains of the powdered leaves; and Trousseau in uterine hemorrhage has given in twenty-four hours one gramme (15.6 grains) of digitalin, the normal dose of which is from $\frac{1}{4}$ to $\frac{1}{2}$ of a grain. The true explanation of the tolerance of such enormous doses must be sought in the experiments which have shown that the real action of digitalis on the heart is that of a stimulator, instead of a paralyzer, of the cardiac muscular substance, which, weakened and exhausted by over-work, high temperature, or profuse hemorrhage, would sustain and even require a dose of digitalis merely to support a sufficient amount of contraction to continue life, which dose in health would fatally tetanize the heart.

OIL OF TURPENTINE AN ANTIDOTE IN POISONING BY PHOSPHORUS (by Hermann Koehler. [Note by K. B. Hofmann, in *Med.-Chirurg.*, *Rundschau*, June, 1873. Translated for the *Detroit Review* by J. Henry Carstens, M.D.]).—The author published (after he had brought his discovery to the notice of the profession) his observations in a paper, "The Value and Significance of the Oil of Turpentine containing Oxygen in Phosphorus Poisoning, etc. Halle, 1872." He sums up the result in the following sentences:

Oil of turpentine containing oxygen is a reliable antidote of phosphorus.

The kind of turpentine, if of this or that species of pine, if German or French (in opposition to Vetter's statement that only the latter has antidotal powers), is of no importance, if it has only not been rectified for some time, and contains oxygen.

The oil of turpentine *only* acts in the stomach, and is best introduced by gelatin capsules: to emulsify the turpentine oil with the yolk of an egg is not advisable, as the latter contains the oil of the egg, which facili-

tates the solution of the phosphorus. For every 0.01 gramme of phosphorus *one* gramme of oil of turpentine as an antidote is sufficient.

The turpentine must be administered as soon as possible after the poisoning. Twenty-four hours after the introduction of the phosphorus the oil of turpentine does not act.

The beneficial action of the antidote is due partly to its containing free oxygen for changing the poisonous phosphorus to the non-poisonous phosphoric acid, and partly by combining with the phosphorus to form the turpentine-phosphorous acid, which is not injurious. This acid, which is only dangerous in very large doses, appears (like laurin and turp. oil camphor) to be eliminated unchanged by the kidneys. It and its salts rapidly absorb oxygen from the air, and oxidize to a resinous derivative of the oil of turpentine, containing phosphoric acid, and this rapid oxidation has prevented an analysis for the ultimate elements.

TAPPING IN HEPATIC ASCITES (*Dublin Journal of Medical Science*, August, 1873).—Dr. John M'Crea reports two cases of ascites which were greatly benefited by repeated tapplings. In the first case the disease was of a rachitic nature, and the treatment, in addition to the withdrawal of the fluid, consisted of the free administration of sal-ammoniac. In the second, diuretics and purgatives failed to make any impression; the operation was repeated fifteen times, and about forty gallons of fluid were withdrawn from the patient. In both cases the accumulation of fluid ceased, and was followed by almost perfect restoration to health.

Dr. M'Crea claims the following advantages for early tapping in hepatic ascites:

1. It relieves intra-portal pressure, and prevents the backward pressure generated by the obstruction from seeking vent in diarrhoea, hemorrhoids, hæmatemesis, etc.
2. The removal of the pressure which the effusion exercises on the liver will facilitate the development of collateral circulation through the more healthy parts of the viscus.
3. The relief of the abdominal tension will make it easier for the vena cava, vena azygos, and parietal abdominal veins to establish a collateral circulation between the abdomen and the chest.
4. The removal of tension from the vena portæ and its branches will promote the absorption of remedies.
5. We clear away an impediment to the digestion and absorption of nutriment.
6. We relieve the kidneys, which exhibit increased activity after each tapping.
7. In ordinary cirrhosis we remove a pressure which is assisting to produce contraction.
8. We afford relief to other important organs, the distress of which makes tapping at least an absolute necessity.
9. We avoid the danger of typhoid peritonitis, which sometimes attends late tapping. Finally, we may hope for better results in liver dropsy by looking on tapping not merely as a palliative, but even as a radical, method of treatment.

SUCCESSFUL (?) REMOVAL OF THE SPLEEN.—In the *Raccogliore Medico*, Dr. Sonsino gives an account of a case in which, on June 20, Dr. Attilio Urbinato of Cesena removed a hypertrophied and mobile spleen. The incision was made in the middle line, and prolonged above the umbilicus, being at least seven inches in length. The operation was performed without much difficulty. After tying three small cutaneous arteries, opening the peritoneum, and drawing aside some loops of intestine, the spleen was seen, free from all abnormal adhesions, and of enormous size. At the inferior part was seen the gastro-splenic epiploön, which was adherent; and

the vessels here were extremely dilated. At the upper part was seen the lower portion of the pancreas. The epiploön was detached, and the vessels tied. The ligatures, seven in number, were left inside without further precaution. The few adhesions of the pancreas were overcome without difficulty, simply by means of the finger. The largest vessels, and the connective tissue which surrounded them, were secured by a metallic loop and hempen ligature. The "toilette" of the abdominal cavity was made with great care. The patient lost but little blood. The ligatures of the vessels tied were passed out between the sutures, of which there were five deep and five superficial. The spleen weighed two and a half pounds. The operation lasted an hour; the patient bore the chloroform well, and subsequently appeared to be progressing favorably, but died of peritonitis three days after the operation.—*British Medical Journal*.

SYPHILITIC ALOPECIA.—That form of syphilitic alopecia which is independent of any eruption affecting the scalp, which accompanies the so-called secondary syphilides, and which is characterized simply by an extensive loss of hair, so that the greater portion of the scalp is denuded absolutely of hair, and not the scalp only, but also the eyebrows and eyelids (of eyelashes) as well, is often a persistent affection, and in my experience is only—very tardily, indeed—remediable by general (mercurial) treatment. I refer to the condition described above, as distinguished from the syphilitic alopecia, resulting commonly (in tertiary syphilis) from the limited and "discrete" loss of hair resulting from the formation of cicatrices consequent on (tertiary) syphilitic ulceration of the scalp. This kind of alopecia, which has by some eminent French writers been assumed to be identical with tinea decalvans (*la teigne pelade*), but which is to be distinguished from any even the most "diffused" forms of the latter disease by its want of definite limitation of margin, is, as I have found, readily (within a month or so) curable by the following topical remedies:

For the scalp, *hydrargyri iodidi rubri*, gr. v; *attar. rosæ*, ℥ij; *olei amygdalæ*, ℥x; *unguenti simplicis*, ʒi.

For the eyebrows (where the skin is more tender), three grains of the mercurial iodide are used. The prescription is otherwise the same as before.

For the eyelids, which are more tender still, five grains of the yellow oxide of mercury, made by the recent method, are substituted for the iodide. The prescription is otherwise as above.

The French writers referred to regard secondary syphilis as merely a predisposing cause of tinea decalvans. I, however, regard the "secondary" syphilitic alopecia as a distinct disease.—*Balmano Squire, M.B., in British Medical Journal*.

A WAX CANDLE IN THE BLADDER OF A FEMALE.—This interesting case was observed a short time ago at the Hôtel-Dieu, Paris. The patient, on admission, complained of intense pain in the abdomen. The urethra, abnormally dilated, easily admitted the finger into the bladder, when a hard, voluminous body was felt. The woman stated that, on account of great difficulty in making water, she had passed a candle through the urethra and had accidentally let it slip into the bladder. It was readily removed with a pair of pincers. The end of the candle, which had been rounded with a knife, was covered with calcareous matter gathered there during the five weeks the candle had stayed in the bladder. Speedy recovery followed.—*Boston Medical and Surgical Journal*.

TOMATO-LEAVES AS A DIURETIC.—A French writer extols the leaves of the tomato (*Solanum Lycopersicon*) as a diuretic.—*Pacific Medical and Surgical Journal*.

PITURI, — A NEW NARCOTIC. — Dr. Bancroft, in a paper read before the Queensland Philosophical Society, enumerates the effects of the leaves of the "pituri," which are used by the natives as a stimulating narcotic in a similar manner to the betel of the East, and which form a substitute for tobacco. After detailing some experiments made with an infusion of the leaves, he thus describes their results:

"1. Period of preliminary excitement from apparent loss of inhibitory power of the cerebrum, attended with rapid respiration; in cats and dogs, with vomiting, and profuse secretion of saliva.

"2. Irregular muscular action, followed by general convulsion.

"3. Paralysis of respiratory function of medulla.

"4. Death, or

"5. Sighing inspirations at long intervals.

"6. Rapid respiration and returning consciousness.

"7. Normal respiration and general torpidity, not unattended with danger to life."

The poison, given by the mouth, acts with less vigor; when it is injected into the intestines the results are more certain. The animal has a longer stage of excitement, the convulsive fit is not so severe, and recovery is more certain. Torpidity remains for some hours. — *London Medical Record*.

ATROPIA IN STRYCHNIA POISONING (*Edinburgh Medical Journal*, September, 1873). — Mr. Samuel Buckley reports the case of a female, æt. 28, who for the purpose of suicide took an indefinite quantity of a patent "vermin-destroyer" containing strychnia. When she was seen, a half-hour later, she was in a state of perfect opisthotonos, with severe and painful spasms at exceedingly short intervals. Treatment was commenced by the inhalation of chloroform, but, this proving useless, atropia was injected subcutaneously, one-sixth grain every ten minutes, until three doses were given. A marked improvement resulted; the spasms grew milder and less frequent, and the expression more natural. The atropia was then given in doses of one-twelfth grain at longer intervals, until $1\frac{1}{2}$ grains had been administered. She then became conscious, the spasms ceased entirely, she fell into a profound but natural sleep, and after awaking suffered no further inconvenience.

The effects of the atropia were so marked in mitigating and counteracting the symptoms that no hesitation was felt in using the very large doses which have been mentioned.

RUPTURE OF THE BLADDER. — Dr. MacEwen reports the case of a lad, nineteen years of age, who had been habituated to excessive indulgence in alcohol, and who died suddenly during a debauch, having had no unusual symptoms except slight colicky pains in the abdomen and a desire to lie with his thighs flexed on his belly. On post-mortem examination the whole abdominal cavity was found to be filled with a straw-colored fluid, inodorous and non-ammoniacal. There were no peritoneal adhesions or inflammatory products of any kind. The thoracic and abdominal viscera were healthy, with the exception of the bladder, in which was discovered an aperture at the junction of the upper and middle thirds posteriorly. There were no ulcerations, appearances of gangrene, organic stricture, obstruction, or false passages. The rupture must have taken place either from temporary paralysis of the bladder, or from spasmodic stricture with violent muscular action in the over-distended viscus. — *The Lancet*, Sept. 27, 1873.

WRITER'S CRAMP (*Irish Hospital Gazette*, October 1, 1873). — Professor C. J. Rossander details the case of a strong, muscular man, æt. 32, who had suffered for two years from an entire inability to form letters or to make

any but perpendicular strokes of a pen. He was unable to move his hand towards the ulnar side, and when he attempted to do so the whole hand was forcibly jerked into the air. There was no loss of power in the arm or hand, other movements were normal, and it was only in attempting to form letters, and particularly several in succession, that the spasmodic action showed itself. Treatment was commenced by the daily injection of ten to twelve drops of a solution containing one per cent. of nitrate of strychnia, and by "massage" or the kneading and rubbing of the muscles of the hand and forearm. At the end of a week there was a decided improvement, and in a month the patient was perfectly restored to health.

REMOVAL OF BOTH SUPERIOR MAXILLARY BONES. — The *Centralblatt für die Medicin. Wissenschaft*. for June 21 contains a brief note of a case related by Podraski in the *Oesterr. Zeitschr. für prakt. Heilkunde*, No. 1, 1873, in which he removed both upper maxillæ from a man aged 42. They were the seat of a tumor which had the appearance of being malignant, being attended with pain and swelling of the lymphatic glands. It was, however, found to be a large ivory exostosis, which had almost obliterated the sinuses and nares. The patient died of pyæmia.

COMBINATION FOR CHRONIC DIARRHŒA. — Rayer advocates the combination of cinchona, charcoal, and bismuth in the management of chronic diarrhœa, in these proportions:

R Subnitrate of bismuth, 3j;
Cinchona, yellow, powdered, 3ss;
Charcoal, vegetable, 3j. M. Chart. xx.

S. Two or three times daily during the intervals between meals. — *Union Médicale*, No. 73.

MISCELLANY.

ANECDOTE OF NÉLATON. — A medical writer tells the following little story of the great French surgeon Nélaton. Speaking of a visit to one of the Paris hospitals, he says, "As we passed into the hall we heard groans, evidently of a child in great pain. The door leading to the sick-ward was ajar, and as we approached we heard the voice of a man talking earnestly with a little sufferer. There was something very affecting in the imploring tones of the child's voice and the tender and sympathizing replies of the physician, and it seemed to us no breach of etiquette to witness unseen, through the crack of the half-open door, the scene that was passing within. On a narrow pallet near the window lay a fine boy, nine or ten years old, dying of cancer developing itself between the eyes and behind the nose. It had not shown itself externally, but had destroyed the sight, and was attended with excruciating suffering. By his side sat a stately white-haired man, holding with one hand the two of the little patient, while with the other he caressingly smoothed his hair. The child told the story of his pain, 'Ah, je souffre tant!' to which the old man listened patiently, promising to devise some relief. Then he rose to go, but first bent over the boy, and, with tears dropping from his eyes, kissed his forehead as lovingly as a mother. The white-haired man was the world-renowned Nélaton, lately summoned to attend the fallen Emperor."

IN the recent inquiry into the condition of the Civil Service in Ireland, it was natural that there should be some reference made to the incomes obtained by professional men in this country. Some extracts from the evidence given may be of interest. Dr. E. Kennedy stated that in Dublin a competent medical man, having the advantages of a hospital and connection, ought, when of ten years' standing, to make from £800 to £1200 a year; if reasonably successful, he ought then to double his income in the course of the next five or six years, and a really successful man ought in a few years more to double his income again; but the instances in which a medical man reaches £6000 a year or £5000 are very rare. The advantage of a hospital physician is that his pupils become scattered about the country and send up patients to him. In the chief provincial towns of Ireland, with a large population, the leading medical man may possibly reach from £1200 to £2000 a year. Sir D. Corrigan, who was also examined, thinks there are perhaps ten or twelve medical men in Dublin making from £2000 to £6000 a year, or more; and there are a great number, whose names are not very prominently before the public, making from £800 to £1000 a year. There are general practitioners in Dublin, men who have never written a line, and who are unknown to the public as men of great eminence, who sometimes accumulate large fortunes.—*London Lancet*.

THE great Dr. Johnson, who said in his day a great many wise things, but also several foolish things, and who thought he knew everything, has thus written in his *Life of Akenside*: "A physician in a great city seems to be the mere plaything of fortune. His degree of reputation is for the most part totally casual: they that employ him know not his excellence; they that reject him know not his deficiencies."

These observations are a bundle of fallacies, and if I think them worth noticing, it is to ask you not to be so mistaken as to believe in them. If you do believe in them, and act on them, you will assuredly repent it. Go through the lives of the eighteen or twenty men included in the volume I have noticed [*The Lives of British Physicians*, extending from Linacre, in 1410, to Gooch's death, in 1830, a period of about four hundred years], and you will learn this: that, whether they were polished in manners like Linacre and Meade, or boorish like Radcliffe, a staunch royalist like Harvey, or a Roundhead like Sydenham, a very martinet in dress like Jenner, or plain as a Quaker in costume like Sir Thomas Browne, there was one quality which all possessed in common, and that it was which placed fortune at their feet,—unremitting hard work in their early days. They were never the playthings of fortune, as Dr. Johnson foolishly ventured to say: they commanded fortune.—*Sir Dominic Corrigan: London Lancet*.

THERE appears to be a great mortality this season among the English grouse, concerning which a correspondent of the *London Lancet* says:

"All birds I have examined during this or former epidemics contained tape-worm. In May last I obtained

two birds, one from the neighborhood of Kirriemuir, the other from Sir Thomas Gladstone's moor, near Fettercairn. Both were in good plumage; the one was emaciated, the other in good condition. The portion of the intestine above the tape-worm was impacted with dry vegetable matter, while the lower part of the gut contained liquid yellow feculent matter. I do not know to what extent the presence of tape-worm in grouse may be consistent with comparative health, and have never myself examined healthy birds for it, but it is well known that all wild animals are liable to be infested with entozoa.

"In the winter of 1846 immense numbers of the razor-billed auk (*Alca torda*) were thrown up dead on the shores of the Firth of Forth. In all the specimens I examined the intestines contained tape-worm and other entozoa, but so familiar was I with these parasites in marine fishes and other animals, that I attributed the auk mortality at the time to the severity of the weather; but certainly neither before nor since have I seen so many of these birds cast on the shore, though there have been many more severe winters."

A STRONG ADHESIVE PASTE.—According to Fr. Sieburger, an excellent paste may be prepared as follows. Four parts, by weight, of glue are soaked for several hours in fifteen parts of water, and then slowly warmed until a perfectly clear solution is formed. This solution is then diluted with sixty-five parts boiling water and thoroughly stirred. In the mean time thirty parts of starch are stirred into two hundred parts of cold water, so as to form a thin, milky liquid, free from lumps. Into this is poured the solution of glue, stirring continually and heating. When cold, ten drops of carbolic acid are added. The paste made in this way is said to possess extraordinary adhesive power, joining leather, paper, pasteboard, etc. By keeping it in closed vessels, so that the water cannot evaporate, it may be preserved for years. Where no great strength is desired, ordinary flour or starch paste is used, a little carbolic acid being added to prevent souring.—*Journal of Applied Chemistry*.

WATER OF ALL FLOWERS.—An ancient formulary of the seventeenth century has this prescription which was to produce a "Water of all Flowers" (*Aqua Florum Omnium*). The process adopted is remarkable for its simplicity and logical accuracy:

"Send a cow into a meadow full of flowers; when she has eaten all the flowers, gather the dung, distil it, and you have water of all flowers."—*Med. and Surg. Reporter*.

SMALLPOX AND VACCINATION.—An official statistical report of the cases of smallpox occurring in the German Empire during the years 1860-71 shows that of 232,824 patients 28,539 died. The condition as to vaccination is stated in 208,793 cases: 27,793 were not vaccinated, and of these 8894, or 32 per cent., died; 181,000 were vaccinated, of whom 17,260, or 9.5 per cent., died; and 6015 were revaccinated, among whom the deaths were 445, or 7.4 per cent.

LUNACY IN MADRAS.—A report on the working of lunatic-asylums in the Madras Presidency has just been submitted to the Right Hon. the Governor in Council. Among the most interesting of its contents is the section on the cause of lunacy. Of the hundred and fifty-three admissions during 1871-72 into the Madras and Vizagapatam asylums, the probable causes of the disease were ascertained in forty-nine cases, and unknown in one hundred and four. Of the former, twelve were attributed to moral and thirty-seven to physical agencies,—"an experience somewhat at variance with results in asylums in other parts of the world." The abuse of narcotic drugs in Bengal caused one hundred and seventy-two out of a total of four hundred admissions, or in the ratio of 43 per cent.; whereas in Madras 7.18 per cent. are ascribed to narcotics, proving that ganjah, bhang, and opium are much more frequently consumed in the north than in the south of India.

ENRICUS CORDUS, who died A.D. 1535, doubtless told his own experience, as well as that of his apostolic succession, in the healing art:

"Tres medicus facies habet: unam quando ragatur,
Angelicam; mox est, cum juvat, ipse Deus.
Post ubi curato, poscit sua preemia, morbo,
Horridus apparat, terribilisque Sathan."

("Three faces wears the doctor: when first sought,
An angel's—and a God's, the cure half wrought;
But when, that cure complete, he seeks his fee,
The devil then looks less terrible than he.")

Pope sang in the same strain, although he was not one of the brotherhood:

"God and the doctor we alike adore,
But only when in danger, not before;
The danger o'er, both are alike requited,
God is forgotten, and the doctor slighted."

Dr. D. Clark, Canada Lancet.

A DILEMMA FOR TEETOTALERS.—We should like to ask the members of the legislature if they are prepared to continue the use of bread as an article of diet, in the face of the following fact, given in the *Medical Press and Circular*:

In the *Chemical News* for May 30, Mr. Bolus says that he has detected a small percentage of alcohol in six samples of new bread purchased at different shops in London. He says, "It is possible that the amount of alcohol contained in bread is too small to be of any dietetic importance, but it may perhaps be worth while to notice that forty two-pound loaves are about equal in alcoholic strength to an ordinary bottle of port."—*Boston Medical and Surgical Journal*.

SOME time ago a Cork gentleman sold some fox-hounds to an English master of hounds. When they arrived at the kennel they were refused, as not being in accordance with their description. They were then sold by auction and purchased by a London dealer in connection with the provision-trade. An action was brought last week at the Liverpool Assizes to recover their value, and one of the learned counsel remarked that they had been made into sausages. They were described as being "lame, mangy, old, and unbroken:"

so perhaps it is as well that we knew nothing about it at the time.—*London Lancet*, Sept. 6, 1873.

PRESERVING CHARRED PAPERS.—Mr. E. H. Hoskins, of Lowell, Massachusetts, has suggested a very useful and practical way of preserving and giving toughness and flexibility to charred paper, which has proved to be of much importance in the identification and copying of valuable documents charred by conflagrations such as the recent Boston and Chicago calamities. We have seen specimens of charred papers and bank-notes, thus treated, that can be handled with impunity. The printing upon the charred bank-notes can be readily discerned. The preserving process consists, we believe, in pouring collodion upon the surface of the charred paper. The collodion forms a thin transparent film, dries in a few minutes, when the process is complete.—*Scientific American*.

COLLODION IN HORTICULTURE.—The *Gazette des Campagnes* recommends dipping the end of plant-slips in collodion before setting them out. The collodion should contain twice as much of cotton as the ordinary material used in photography. Let the first coat dry, and then dip again. After planting the slip, the development of the roots will take place very promptly. This method is said to be particularly efficacious with woody slips, geraniums, fuchsias, and similar plants.—*Boston Journal of Chemistry*.

DOCTORS ON A STRIKE.—The *Gazette Hebdomadaire* mentions a strike of medical practitioners of the Canton of Aargau, Switzerland, on account of the miserably small fees allowed them for visiting the poor. It appears that a physician is entitled to about fifteen cents for visits at a distance of nearly a mile.—*New York Medical Journal*.

MISS DR. FRANCES A. RUTHERFORD has been appointed Vice-President of the Michigan State Medical Society. Miss Rutherford is the happy possessor of a Philadelphia degree.—*London Lancet*, Sept. 6, 1873.

CALOMEL FOR PILES.—Calomel applied once or twice a day to tumid and tender piles rarely fails to cure them in a few days.—*Western Lancet*.

THIRTY-SEVEN ladies are said to have matriculated already in the Medical Department of the Michigan University.

COST OF AN EPIDEMIC.—The *London Medical Record*, April 16, 1873, states that the late smallpox epidemic cost Dublin at least £35,000.

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY, FROM OCTOBER 21, 1873, TO OCTOBER 27, 1873, INCLUSIVE.

GIRARD, A. C., ASSISTANT-SURGEON.—Assigned to duty at Yorkville, South Carolina. S. O. 180, Department of the South, October 20, 1873.

MATTHEWS, W., ASSISTANT-SURGEON.—To report in person at these Headquarters for assignment. S. O. 206, Department of the East, October 22, 1873.

BYRNE, C. B., ASSISTANT-SURGEON.—Assigned to temporary duty at Wilt's Point, New York Harbor. S. O. 210, A. G. O., October 23, 1873.